

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06396**

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bembes Pt.		e. STREET ADDRESS Bembes Pt.	
3. NAME OF DECEASED (Type or print) First Middle Last ERNEST EDWARD ADAMS		4. DATE OF DEATH Month Day Year 6 - 19 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 28th 1881
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineman	11. BIRTHPLACE (State or foreign country) Somerset Co Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas B. Adams	
14. MOTHER'S MAIDEN NAME Margaret Mulligan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary E. Adams (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac disease DUE TO 4344 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE E. Linhardt		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) E. Linhardt		DATE SIGNED 6/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 6-22-58	
22c. NAME OF CEMETERY OR CREMATORY Wheatland		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Scyler		24a. REC'D BY REGISTRAR JUN 23 '58	
24b. REGISTRAR'S SIGNATURE W. E. Leach		24c. ADDRESS Annapolis Md	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE BOARD OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE IN DEATH
CERTIFICATE

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

BIRTH

DEATH

INTERVIEW

TESTIMONY

OPINION

REMARKS

SIGNATURE

DATE

PLACE

CAUSE

MANNER

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

BIRTH

DEATH

INTERVIEW

TESTIMONY

OPINION

REMARKS

SIGNATURE

DATE

PLACE

CAUSE

MANNER

AGE

SEX

RACE

RELIGION

CERTIFICATE OF DEATH

06397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Children's Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>O. Andrews</u> Last <u></u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Children's Center</u>	
11. BIRTHPLACE (State or foreign country) <u>Haldon Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Andrews</u>		14. MOTHER'S MAIDEN NAME <u>F. May Allison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Family records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Generalized Atherosclerosis & Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>June 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>58</u> , and that death occurred at <u>6:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert O. Wingfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel, Maryland</u> DATE SIGNED <u>June 19, 1958</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT O. WINGFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beaumont Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. Randolph</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>W. H. H. Randolph</u> DATE <u>JUN 24 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. H. Randolph</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18

Items 1, 13, 14, Fill in G231 7-3-58 et

6426

CERTIFICATE OF DEATH

06398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garland Park</i>		c. LENGTH OF STAY IN 1b <i>4 or 5 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS <i>1 104 Oak Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Edward</i> Last <i>Anthony</i>		4. DATE OF DEATH Month <i>June</i> Day <i>24</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 17, 1915</i>
9. AGE (In years last birthday) <i>43 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Black Smith</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shoe repair</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Anthony</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Hendricks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-014824</i>	
17. INFORMANT <i>Mr. J. H. Walk</i>		Address <i>Takes 17th. Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Vascular Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Decomposition</i> (b) <i>Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 or 4 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. —19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1957</i> , to <i>June 24</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>June 24</i> , 19 <i>58</i> , and that death occurred at <i>1 P.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>108 Central Ave Glen Burnie Md</i> DATE SIGNED ACTUAL SIGNATURE <i>James S. Bellingsh</i> M.D. PHYSICIAN'S NAME (Type) <i>James S. Bellingsh</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>June 27-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or County) (State) <i>Rutledge Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Blondine A. Fink</i>		ADDRESS <i>Glen Burnie Md</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

CERTIFICATE OF DEATH

1928

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CLERK	
JAMES J. JAMES		M		45		JAN 1 1883		BOSTON		LABORER		HEART DISEASE		HOSPITAL		10:30 AM		J. J. JAMES		D. D. D.		C. C. C.	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF CLERGYMAN		17. NAME OF FUNERAL HOME		18. NAME OF BURIAL PLACE		19. NAME OF CEMETERY		20. NAME OF CHURCH		21. NAME OF PARISH		22. NAME OF DISTRICT		23. NAME OF TOWN		24. NAME OF COUNTY	
CATHOLIC CHURCH		ST. MARY'S		JAN 10 1928		FATHER J. J. JAMES		JAMES J. JAMES		ST. MARY'S		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH	
25. NAME OF REGISTRAR		26. NAME OF PHYSICIAN		27. NAME OF CLERK		28. NAME OF FUNERAL HOME		29. NAME OF BURIAL PLACE		30. NAME OF CEMETERY		31. NAME OF CHURCH		32. NAME OF PARISH		33. NAME OF DISTRICT		34. NAME OF TOWN		35. NAME OF COUNTY		36. NAME OF STATE	
J. J. JAMES		D. D. D.		C. C. C.		JAMES J. JAMES		ST. MARY'S		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH		CATHOLIC CHURCH	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

CERTIFICATE OF DEATH

06399

Reg. Dist. No.

6403

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				/d. STREET ADDRESS <u>Rt. 9, Box 345</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>"Baby"</u> Middle <u>Boy</u> Last <u>Arkuszski</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1958</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>20</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John Anthony Arkuszski</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Trimble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>John A. Arkuszski</u> (Father)				Address <u>Rt. 9, Box 345, Pasadena, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>placenta previa i hemorrhage</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/26</u> 19 <u>58</u> , to <u>6/26</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6/26</u> 19 <u>58</u> , and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6/27/58</u>							
ACTUAL SIGNATURE <u>S. Borssuch</u> M.D.				PHYSICIAN'S NAME (Type) <u>S. Borssuch</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Brooklyn, BFD, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

27634-16 XVI

CERTIFICATE OF DEATH

1-03

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. MEDICAL HISTORY		11. HISTORY OF PRESENT ILLNESS		12. POST-MORTEM EXAMINATION	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN	
19. SIGNATURE OF CLERGY		20. SIGNATURE OF BURIAL		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
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34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
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43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
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49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
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73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
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79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
RECEIVED
JAN 10 1903
BOSTON

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 231 7-7-58									
6427									
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
Reg. Dist. 14.									
1. PLACE OF DEATH a. COUNTY A.A. Co					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie					c. LENGTH OF STAY IN 1b x Glen Burnie				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 Harford Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Alice A. Bailey					4. DATE OF DEATH Month Day Year JUNE 22 1958				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 11-1885		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY W. Va.			11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME UNKNOWN					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. NONE		17. INFORMANT Ruby Bailey		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO ANOXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE (c) 3 DA. 3-4 YRS.					INTERVAL BETWEEN ONSET AND DEATH 3 DA. 3-4 YRS.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) METASTATIC CARCINOMA TO LIVER, 1st 2nd 3rd BURNS ABDOMEN & THIGHS									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (Burns healed at time of death)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from NOV. 1957, to JUNE 1958, that I last saw the deceased alive on JUNE 20, 1958, and that death occurred at 1:58 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Leon C. Perry M.D. 201 B + A BLVD, GLEN BURNIE, MD. 6-22-58 PHYSICIAN'S NAME (Type) LEON C. PERRY, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF June-25-58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			22d. LOCATION (City, town, or county) Princeton W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE X. V. Singleton, Glen Burnie					24a. REC'D BY REGISTRAR DATE JUN 25 '58		24b. REGISTRAR'S SIGNATURE W. Deane		

6428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum			c. LENGTH OF STAY IN 1b 32 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Linthicum	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Sycamore Road				d. STREET ADDRESS 111 Sycamore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SARA EDITH BARNES				4. DATE OF DEATH Month Day Year June 27, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17/98	
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John O. Jones				14. MOTHER'S MAIDEN NAME Mary E. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Mr. John F. Barnes, Sr., Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lt. Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 170X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 57 to June 27, 19 58 that I last saw the deceased alive on June 25, 19 58 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Linthicum, Md. 6/27/58							
ACTUAL SIGNATURE Chas. L. Ball, Jr. M.D.				PHYSICIAN'S NAME (Type) Charles L. Ball, M.D. Linthicum, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30/58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Glen Burnie, Md.				24a. REC'D BY REGISTRAR JUL 1 1958		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

100

6. *Notes on the author.* The author is a 22-year-old male, 1.75 m tall, 70 kg, with a body fat percentage of 12.5%.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6404

06402

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANNO</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Annapolis</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. Gen'l. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>315 - West 31st St</u>	
3. NAME OF DECEASED:	(First) <u>George</u>	(Middle) <u>A.</u>	(Last) <u>BASKIN</u>
(Type or Print)			
4. DATE OF DEATH	(Month) <u>6</u>	(Day) <u>19</u>	(Year) <u>1958</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Sept. 6, 1889</u>
9. AGE last birthday: <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Self Emp;</u>	10b. KIND OF BUSINESS OR INDUSTRY: <u>Elec. Contractor</u>	11. BIRTHPLACE (State or foreign country): <u>S. C.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Wm. M. Baskin</u>		14. MOTHER'S MAIDEN NAME: <u>Rozanna Leslie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY No.: <u>-212-22-9260</u>	
		17. INFORMANT & ADDRESS: <u>Mrs. Estelle M. Baskin - 315 W. 31st St.</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
<u>434.4</u> Immediate cause (a) <u>Heart Disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			<u>Sudden</u>
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>E. W. Hacht</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>6-19-58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>6/23/58</u>	NAME OF CEMETERY OR CREMATORY: <u>Baltimore National Cem.</u>	LOCATION (City, town, or county) (State): <u>Balto., Md.</u>
DATE REC'D BY LOCAL REG. <u>JUN 23 58</u>	REGISTRAR'S SIGNATURE <u>E. W. Hacht</u>	24. FUNERAL DIRECTOR <u>Wm. J. Lickner & Sons</u>	ADDRESS <u>Balto. 17th</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6405

CERTIFICATE OF DEATH

06403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>526 Sixth Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ardell</u> Middle <u>Allin</u> Last <u>Bentley, Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1958</u>	9. AGE (In years last birthday) yrs. <u>17</u> Mo. <u>51</u>	IF UNDER 1 YEAR Months <u>17</u> Days <u>51</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Ardell Allin Bentley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Irma Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>526 Sixth Street, Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 day</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4 June, 1958</u> , to <u>5 June, 1958</u> , that I last saw the deceased alive on <u>5 June, 1958</u> , and that death occurred at <u>6:50 p. m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>121 Cathedral St. Annapolis June 5-58</u>			
PHYSICIAN'S NAME (Type) <u>STUART H. WALKER MD</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Millcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2163232XVI

CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE _____		4. DATE OF BIRTH _____	
5. PLACE OF BIRTH _____		6. PLACE OF DEATH _____	
7. OCCUPATION _____		8. CAUSE OF DEATH _____	
9. MEDICAL HISTORY _____		10. SIGNATURE OF PHYSICIAN _____	
11. SIGNATURE OF REGISTRAR _____		12. DATE OF DEATH _____	
13. TIME OF DEATH _____		14. PLACE OF INTERMENT _____	
15. NAME OF FUNERAL HOME _____		16. NAME OF FUNERAL HOME _____	
17. NAME OF FUNERAL HOME _____		18. NAME OF FUNERAL HOME _____	
19. NAME OF FUNERAL HOME _____		20. NAME OF FUNERAL HOME _____	
21. NAME OF FUNERAL HOME _____		22. NAME OF FUNERAL HOME _____	
23. NAME OF FUNERAL HOME _____		24. NAME OF FUNERAL HOME _____	
25. NAME OF FUNERAL HOME _____		26. NAME OF FUNERAL HOME _____	
27. NAME OF FUNERAL HOME _____		28. NAME OF FUNERAL HOME _____	
29. NAME OF FUNERAL HOME _____		30. NAME OF FUNERAL HOME _____	
31. NAME OF FUNERAL HOME _____		32. NAME OF FUNERAL HOME _____	
33. NAME OF FUNERAL HOME _____		34. NAME OF FUNERAL HOME _____	
35. NAME OF FUNERAL HOME _____		36. NAME OF FUNERAL HOME _____	
37. NAME OF FUNERAL HOME _____		38. NAME OF FUNERAL HOME _____	
39. NAME OF FUNERAL HOME _____		40. NAME OF FUNERAL HOME _____	
41. NAME OF FUNERAL HOME _____		42. NAME OF FUNERAL HOME _____	
43. NAME OF FUNERAL HOME _____		44. NAME OF FUNERAL HOME _____	
45. NAME OF FUNERAL HOME _____		46. NAME OF FUNERAL HOME _____	
47. NAME OF FUNERAL HOME _____		48. NAME OF FUNERAL HOME _____	
49. NAME OF FUNERAL HOME _____		50. NAME OF FUNERAL HOME _____	
51. NAME OF FUNERAL HOME _____		52. NAME OF FUNERAL HOME _____	
53. NAME OF FUNERAL HOME _____		54. NAME OF FUNERAL HOME _____	
55. NAME OF FUNERAL HOME _____		56. NAME OF FUNERAL HOME _____	
57. NAME OF FUNERAL HOME _____		58. NAME OF FUNERAL HOME _____	
59. NAME OF FUNERAL HOME _____		60. NAME OF FUNERAL HOME _____	
61. NAME OF FUNERAL HOME _____		62. NAME OF FUNERAL HOME _____	
63. NAME OF FUNERAL HOME _____		64. NAME OF FUNERAL HOME _____	
65. NAME OF FUNERAL HOME _____		66. NAME OF FUNERAL HOME _____	
67. NAME OF FUNERAL HOME _____		68. NAME OF FUNERAL HOME _____	
69. NAME OF FUNERAL HOME _____		70. NAME OF FUNERAL HOME _____	
71. NAME OF FUNERAL HOME _____		72. NAME OF FUNERAL HOME _____	
73. NAME OF FUNERAL HOME _____		74. NAME OF FUNERAL HOME _____	
75. NAME OF FUNERAL HOME _____		76. NAME OF FUNERAL HOME _____	
77. NAME OF FUNERAL HOME _____		78. NAME OF FUNERAL HOME _____	
79. NAME OF FUNERAL HOME _____		80. NAME OF FUNERAL HOME _____	
81. NAME OF FUNERAL HOME _____		82. NAME OF FUNERAL HOME _____	
83. NAME OF FUNERAL HOME _____		84. NAME OF FUNERAL HOME _____	
85. NAME OF FUNERAL HOME _____		86. NAME OF FUNERAL HOME _____	
87. NAME OF FUNERAL HOME _____		88. NAME OF FUNERAL HOME _____	
89. NAME OF FUNERAL HOME _____		90. NAME OF FUNERAL HOME _____	
91. NAME OF FUNERAL HOME _____		92. NAME OF FUNERAL HOME _____	
93. NAME OF FUNERAL HOME _____		94. NAME OF FUNERAL HOME _____	
95. NAME OF FUNERAL HOME _____		96. NAME OF FUNERAL HOME _____	
97. NAME OF FUNERAL HOME _____		98. NAME OF FUNERAL HOME _____	
99. NAME OF FUNERAL HOME _____		100. NAME OF FUNERAL HOME _____	

CHIEF CLERK
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND

This certificate is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6406
CERTIFICATE OF DEATH

Reg. Dist. No. 06404

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>526 Sixth Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>Bentley</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1958</u>
9. AGE (In years last birthday) yrs. <u>17</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>17</u> Days <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ardell Allin Bentley</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Irma Hopkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mother</u>		Address <u>526 Sixth Street, Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4 June 1958</u> to <u>5 June 1958</u> , that I last saw the deceased alive on <u>5 June 1958</u> , and that death occurred at <u>6:30 M</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stuart Walker MD</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis</u> DATE SIGNED <u>5 June 58</u>	
PHYSICIAN'S NAME (Type) <u>STUART WALKER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) <u>Annapolis Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

2263235XVI

6407

CERTIFICATE OF DEATH

06405

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>3 DA.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSPITAL</u>				d. STREET ADDRESS <u>1 RTE 1, Box 170-B</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>EARL</u>		First <u>EARL</u>		Middle <u>H.</u>		Last <u>BOETTCHER</u>	
4. DATE OF DEATH Month <u>6</u>		Day <u>10</u>		Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/18</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u>39</u>	IF UNDER 24 HRS. Days <u>10</u>	Hours <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman-Assit Chief</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Academy Fire Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adolph Boettcher</u>				14. MOTHER'S MAIDEN NAME <u>Edith Mitchel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>219-01-1882</u>		17. INFORMANT Address <u>Mrs Frances E. Boettcher- Wife- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHOLELITHIASIS + CHOLECYSTITIS</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	Month <u>19</u>	Day <u>19</u>	Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>ANNAPOLIS, MD.</u>	(County) <u>ANNAPOLIS</u>
21. I certify that I attended the deceased from <u>FEB</u> , 19 <u>58</u> , to <u>6/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/10/58</u> , 19 <u>58</u> , and that death occurred at <u>9:35P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peeler</u>				ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, MD.</u>			
DATE SIGNED <u>6/10/58</u>							
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>				<u>ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6408

CERTIFICATE OF DEATH

Reg. Dist. No. **66496**

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. General</u>				d. STREET ADDRESS <u>1 Elliott Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Buser</u> Last <u>Sr</u>				4. DATE OF DEATH Month <u>6</u> - Day <u>2</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 27 - 1869</u>		9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gardner</u>		11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Henry Buser</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Weiss</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Elise Buser</u> Address <u>(2)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary Edema</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of prostate</u> DUE TO (c) <u>metastatic tumor</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u> <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>2-5-58</u> , 19 <u>58</u> , to <u>6-2-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-2-58</u> , 19 <u>58</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St. G-3-58</u> DATE SIGNED <u> </u>									
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.				PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u> <u>Annapolis, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Faylen Sons</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6429

CERTIFICATE OF DEATH

66407

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAMBRILLS		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM F BUTLER		4. DATE OF DEATH JUNE 11 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Prince George Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. James Leddy- Daughter-		Address Southgate Ave. Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 1/2 yrs. 10 Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1946 to June 11 1958 , that I last saw the deceased alive on June 6 1958 , and that death occurred at 7:54 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward Skeritt M.D.		ADDRESS (Street, city or town, state) Gambrills, Maryland	
DATE SIGNED 6-13-58			
PHYSICIAN'S NAME (Type) Edward Skeritt MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 14, 58	22c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields	22d. LOCATION (City, town, or county) (State) Millersville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR 16 '58 24b. REGISTRAR'S SIGNATURE W. E. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

5223

1. NAME OF DECEASED

2. SEX

3. RACE

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. SEX

8. OCCUPATION

9. CAUSE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. PLACE OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF CLERK

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESS

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF CORONER

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF CLERK

28. SIGNATURE OF REGISTRAR

29. SIGNATURE OF DECEASED

30. SIGNATURE OF WITNESS

31. SIGNATURE OF PHYSICIAN

32. SIGNATURE OF CORONER

33. SIGNATURE OF JURY

34. SIGNATURE OF JUDGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6430
CERTIFICATE OF DEATH

06408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b 22y 9m 23d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Unknown c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Shirley		4. DATE OF DEATH Month 6 Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) yrs. 63?
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lillian Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic Carcinoma of the left lung with metastases DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paranoid Schizophrenic INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from July 56 to June 3 19 58 , that I last saw the deceased alive on June 3 , 19 58 , and that death occurred at 1:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 6-3-58 ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Ward Mapp		24. REC'D BY REGISTRAR DATE JUN 11 '58	
24. REGISTRAR'S SIGNATURE W. J. Mapp			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6431

66409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY in 1b <u>15 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>601 Tranton Rd.</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>George Joseph Carroll</u>			4. DATE OF DEATH Month <u>June</u> Day <u>21st.</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/99</u>	9. AGE (in years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Boiler Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Elliston Carroll (son.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asthma</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 22 1958</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		22e. (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6432

CERTIFICATE OF DEATH

Reg. Dist. **66410**

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach Pasadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach Pasadena Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 209 Dale Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER Shelton Chaney				4. DATE OF DEATH Month Day Year June 28 1958			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept-8, 1875	9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY SAME		11. BIRTHPLACE (State or foreign country) USA - A.A. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Richard Chaney				14. MOTHER'S MAIDEN NAME Mary Elizabeth Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-03-5448A		17. INFORMANT Katherine Chaney			Address Dale Rd Pasadena Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 420.0 DUE TO CARDIAC DECOMPENSATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 15 min 5 1/2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/11 1958 to 6/27 1958 , that I last saw the deceased alive on 6/27 1958 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 715 Cotton Rd Glen Burnie Md	
ACTUAL SIGNATURE R. W. Prichard		M.D.		DATE SIGNED 6/28/58			
PHYSICIAN'S NAME (Type) R. W. PRICHARD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/1/58	22c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE		22d. LOCATION (City, town, or county) (State) HOWARD COUNTY, Md			
23. FUNERAL DIRECTOR'S SIGNATURE Harold B. Birtney				24a. REC'D BY REGISTRAR JUL 1 1958		24b. REGISTRAR'S SIGNATURE Overman	

CERTIFICATE OF DEATH

1938

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		DEATH	
LOCALITY		COUNTY	
AGE		SEX	
MARRIAGE		RELATIONSHIP	
OCCUPATION		EDUCATION	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
POSTMORTEM EXAMINATION		LABORATORY EXAMINATIONS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH-DEATH REGISTRY

1

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH-DEATH REGISTRY

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6433

CERTIFICATE OF DEATH

Reg. Dist. No.

06411

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>304 Hilltop Rd.</u>		d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Ernest</u> Last <u>Clarke</u>		4. DATE OF DEATH <u>June 13 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20 1888</u> 9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CPA</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>J. Beauregard Clarke</u>		14. MOTHER'S MAIDEN NAME <u>Ella Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-12-9784</u> 17. INFORMANT <u>Angela Clarke</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8-9 yrs.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 13 1958</u> to <u>6/13 1958</u> , that I last saw the deceased alive on <u>June 13 1958</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D. <u>Linthicum</u>		ADDRESS (Street, city or town, state) <u>6/13/58</u> DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Jessup, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons</u> ADDRESS <u>Balto. Md.</u>		24a. REC'D BY REGISTRAR <u>16 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

COUNTY OF MARYLAND DISTRICT OF BALTIMORE		DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH	
OCCUPATION PLACE OF DEATH DATE OF DEATH TIME OF DEATH		CAUSE OF DEATH 1. IMMEDIATE CAUSE 2. INTERMEDIATE CAUSE 3. REMOTE CAUSE	
MANNER OF DEATH 1. ACCIDENT 2. SUICIDE 3. HOMICIDE 4. NATURAL CAUSE 5. UNKNOWN		MEDICAL HISTORY PREVIOUS ILLNESS PREVIOUS SURGERY PREVIOUS TRAUMA PREVIOUS DRUGS PREVIOUS ALCOHOL	
SIGNATURE OF PHYSICIAN NAME ADDRESS CITY STATE ZIP		SIGNATURE OF REGISTRAR NAME ADDRESS CITY STATE ZIP	
SIGNATURE OF WITNESS NAME ADDRESS CITY STATE ZIP		SIGNATURE OF WITNESS NAME ADDRESS CITY STATE ZIP	

6434 CERTIFICATE OF DEATH

Reg. Dist. No.

I. PLACE OF DEATH:

COUNTY

Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY
OR and give nearest town) (in this place)
TOWN Isle Burnie, Md. 14 moHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2 Queen Anne Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Baltimore City

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN 30 E. West StSTREET
ADDRESS(If rural give location)
Baltimore, Md. 02X-13. NAME OF
DECEASED:

(First)

(Middle)

(Last)

MARY

SUSAN

CLINTON

5. SEX:

F

6. COLOR OR
RACE:

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

married

8. DATE OF BIRTH:

20 May 1889

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

June

3

19 58

9. AGE last birthday:

69

If UNDER 1 YEAR

If UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired):

Hwy.

10b. KIND OF BUSINESS OR
INDUSTRY:

Home

11. BIRTHPLACE (State or foreign country):

Harford County, Md.

12. CITIZEN OF WHAT
COUNTRY?

Yes

13. FATHER'S NAME:

Charles R. MARRELL (dec)

14. MOTHER'S MAIDEN NAME:

Kirkie Schultz (dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

Husb. Samuel R. Clinton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

acute nephritis

DUE TO

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b)

Cerebral Vascular Accident

DUE TO

(c)

Hypertension

Interval Between
Onset And Death

2 weeks

2 yrs

10 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

none

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

None

PLACE (Home, farm, factory, street,
office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURY June 3 1958 12:45

INJURY OCCURRED

While at
Work ☒Not While
At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 2 June, 1958, to 3 June, 1958, that I last saw the deceased

alive on 2 June 1958, and that death occurred at 12:45 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H-F Manuzak M.D.

901 Edgerly Rd, Glen Burnie, Md

3 June 1958

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

6-6-58

NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

LOCATION (City, town, or county)

5829 Ritchie Highway

(State)

DATE REC'D BY LOCAL
REGISTRAR

JUN 4 '58

REGISTRAR'S SIGNATURE

W. L. Leach

24. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul Street

Note - Patient has been under medical care by five other doctors.

MARGIN RESERVED FOR BINDING

RECEIVED

RECEIVED

RECEIVED

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RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6435

CERTIFICATE OF DEATH

Reg. Dist. No. **06413**

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1 day			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville				d. STREET ADDRESS 08X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Robert Last Cole				4. DATE OF DEATH Month 6 Day 1 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 219 01 3547		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebralvascular Accident (probably thrombosis) DUE TO (c) Hypertensive and Arteriosclerotic Cardiovascular Disease.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility and mal-nutrition.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/30/58 to 6/1/58 , that I last saw the deceased alive on 6/1/58 and that death occurred at 9:45P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.				DATE SIGNED 6/1/58	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md.				6/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-5-58		22c. NAME OF CEMETERY OR CREMATORY ST MARY'S		22d. LOCATION (City, town, or county) (State) Bryantown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home				ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial-transit permit, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06414

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <i>Cal.</i> b. COUNTY <i>Los Angeles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ferdinand Herman Congelman</i>		4. DATE OF DEATH Month <i>6</i> Day <i>7</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-2-1897</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>St Louis Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Fred Congelman</i>		14. MOTHER'S MAIDEN NAME <i>Anna Kern</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Lillie M. Congelman</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-7-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Forest Lawn</i>		22d. LOCATION (City, town, or county) (State) <i>Glendale Cal.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>JUN 9</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>	

12
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Came for son's graduation U.S.N. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #4 - Film #230 - 6/27/58 - mb

6436

CERTIFICATE OF DEATH

Reg. Dist. No. 27

06415

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Fort Meade</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. A. Hospital</u>				d. STREET ADDRESS <u>20 Elm St Country Club Estates</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND A DEARDORF</u>				4. DATE OF DEATH Month Day Year <u>June 6 519 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1898</u>	
9. AGE (In years last birthday) yrs. <u>59</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Sylvester Deardorf</u>				14. MOTHER'S MAIDEN NAME <u>Margarett (last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>Vet WW 1 & 2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Opal Deardorf</u> Address <u>20 Elm St, Country Club Estates</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion (suspected)</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dead on Arrival</u> , to <u>June 6, 1958</u> , that I last saw the deceased alive on <u>June 6, 1958</u> , and that death occurred at <u>735 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U. S. ARMY HOSPITAL, Ft Meade, Md</u> <u>6 Jun 58</u>							
ACTUAL SIGNATURE <u>John R. Robertson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JOHN R. ROBERTSON, CAPT, MO, US. ARMY HOSPITAL, FT GEORGE G. MEADE, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem - Fort Myer, Va.</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>R. J. Singleton</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6410

CERTIFICATE OF DEATH

06416

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. El. General</i>				d. STREET ADDRESS <i>1000 Bay Ridge Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Oslando H. Duwall</i>				4. DATE OF DEATH <i>6-19-1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-11-1875</i>	9. AGE (In years last birthday) <i>82</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy Farming</i>		11. BIRTHPLACE (State or foreign country) <i>A. A. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Richard Duwall</i>				14. MOTHER'S MAIDEN NAME <i>Laura Hancock</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs W. Clyde Mills</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>-</i> DUE TO (c) <i>arteriosclerotic cardiovascular disease</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Jan</i> 19 <i>50</i> , to <i>6-19</i> 19 <i>58</i> , that I last saw the deceased alive on <i>6-18</i> 19 <i>58</i> , and that death occurred at <i>11:30</i> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>S. Borssuets</i> M.D.				ADDRESS (Street, city or town, state) <i>Annapolis Md</i> DATE SIGNED <i>6/16/58</i>			
PHYSICIAN'S NAME (Type) <i>S. Borssuets</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-22-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Margarets</i>		22d. LOCATION (City, town, or county) (State) <i>St Margarets 296 Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i> ADDRESS <i>Annapolis Md.</i>				24a. REC'D BY REGISTRAR <i>JUN 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06417

6437

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade				c. LENGTH OF STAY IN 1b 20 Minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				d. STREET ADDRESS Box #2 Jessup, Md			
3. NAME OF DECEASED (Type or print) First TINA Middle MARIE Last ESTES				4. DATE OF DEATH Month June Day 5 Year 1958			
5. SEX Female		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 5, 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME VON RAY ESTES				14. MOTHER'S MAIDEN NAME BONNIE KATE HOWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Father Von Estes Address Box 2 Jessup, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature, immaturity DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 20 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 June, 1958 , to 5 June, 1958 , that I last saw the deceased alive on 5 June, 1958 , and that death occurred at 2:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Neil S. Stewart M.D. II. S. ARMY HOSP., FT MEADE, MD 5 June 58							
PHYSICIAN'S NAME (Type) NEIL S. STEWART, CAPT, MC, US ARMY HOSPITAL, FT MEADE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/9/58		22c. NAME OF CEMETERY OR CREMATORY Balto National		22d. LOCATION (City, town, or county) (State) Balto City	
23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Wolcott				24a. REC'D BY REGISTRAR 6/11/58		24b. REGISTRAR'S SIGNATURE W. L. Leach	

CERTIFICATE OF DEATH

1933

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
Jan 15, 1933		Home		Heart Disease		Natural	
Time of Death		Physician		Hospital		Burial Place	
10:30 AM		Dr. Smith		St. Mary's		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Cause of Report		Manner of Report	
Jan 16, 1933		Home		Heart Disease		Natural	
Time of Report		Physician		Hospital		Burial Place	
11:00 AM		Dr. Smith		St. Mary's		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6438

CERTIFICATE OF DEATH

06418

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle MARY Last GARBER		4. DATE OF DEATH Month 6 Day 15 Year 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1893
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JOHN HOUK		14. MOTHER'S MAIDEN NAME MARY HODGES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Address RAYMOND G. GARBER, 2816 E. Young Street, Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BREAST CA WITH METASTASES 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) IN LUNGS AND BONES DUE TO (c) 13 mo		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-4 , 19 58 , to 6-14 , 19 58 , that I last saw the deceased alive on 6-14-58 , 19 58 , and that death occurred at 12:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Otto Vogel MD M.D.		ADDRESS (Street, city or town, state) Box 441-A DATE SIGNED 6-15-58	
PHYSICIAN'S NAME (Type) OTTO VOGEL, M.D.		PASADENA, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-17-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham ADDRESS Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JUN 17 58	
		24b. REGISTRAR'S SIGNATURE W. J. Eubank	

F.C. Hymnbottom. Ellcott City, Md.

Journal 6-17-58 Baltimore National Baltimore

1958

TO BE RETURNED TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6439

CERTIFICATE OF DEATH

06419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>40 y.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Gellert</u> Last <u>Gellert</u>				4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11. 1903</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>machinery</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Gellert</u>				14. MOTHER'S MAIDEN NAME <u>Christina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Henry Gellert</u> Address <u>Rte 2 Box 663, Severna Park</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of the heart</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary artery disease</u> (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Glen Burnie, Md.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1957</u> , to <u>June 1958</u> , that I last saw the deceased alive on <u>June 5 1958</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew Szabo</u>				ADDRESS (Street, city or town, state) <u>3 Crain Highway, Glen Burnie, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Andrew Szabo, M.D.</u>				DATE SIGNED <u>6/7/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PK Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>West</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1938

Reg. Dist. No.

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR OF SKIN</p> <p>9. CAUSE OF DEATH</p> <p>10. PLACE OF DEATH</p> <p>11. TIME OF DEATH</p> <p>12. SIGNATURE OF REGISTRAR</p> <p>13. SIGNATURE OF PHYSICIAN</p> <p>14. SIGNATURE OF FUNERAL HOME</p> <p>15. SIGNATURE OF WITNESSES</p> <p>16. SIGNATURE OF CORONER</p> <p>17. SIGNATURE OF JUDGE</p> <p>18. SIGNATURE OF CLERK</p> <p>19. SIGNATURE OF NOTARY</p> <p>20. SIGNATURE OF SHERIFF</p> <p>21. SIGNATURE OF DEPUTY SHERIFF</p> <p>22. SIGNATURE OF CONSTABLE</p> <p>23. SIGNATURE OF JURY</p> <p>24. SIGNATURE OF GRAND JURY</p> <p>25. SIGNATURE OF DISTRICT COURT</p> <p>26. SIGNATURE OF CIRCUIT COURT</p> <p>27. SIGNATURE OF APPELLATE COURT</p> <p>28. SIGNATURE OF SUPREME COURT</p> <p>29. SIGNATURE OF U.S. DISTRICT COURT</p> <p>30. SIGNATURE OF U.S. SUPREME COURT</p>	
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ALL FORMS OF CHANGING ADDRESS AND ALL OTHERS NOT BEING CHANGED BY THE REGISTRAR SHALL BE CHANGED BY THE REGISTRAR AT HIS OWN RISK AND WITHOUT LIABILITY TO THE STATE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
6440 Item 7 Film G231 7-7-58 et
CERTIFICATE OF DEATH

06420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crofton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leroy Drive				d. STREET ADDRESS 528 1/2 Walnut St			
3. NAME OF DECEASED (Type or print) First Samuel Middle - Last Corrad				4. DATE OF DEATH Month JUNE Day 29 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21 - 1875		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY (Self) Retired		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH NONE	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-22 , 19 58 , to 6-29 , 19 58 , that I last saw the deceased alive on 6-22 , 19 58 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leon C. Perry, M.D. 201 B & A BLVD 6-29-58							
ACTUAL SIGNATURE Leon C. Perry, M.D.				PHYSICIAN'S NAME (Type) LEON C. PERRY, M.D. GLEN BURNIE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-58		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		22d. LOCATION (City, town, or county) (State) Charlestown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Miss Kelly Jones				ADDRESS 1306 2nd Avenue		24a. REC'D BY REGISTRAR DATE JUL 1 '58	
				24b. REGISTRAR'S SIGNATURE Alb. Leach			

1. The first part of the document is a letter from the author to the editor, dated 1922. The letter discusses the author's interest in the subject of the journal and the importance of the work being presented. The author mentions that the work is a result of a long and arduous process, and that it is hoped that the journal will provide a platform for the work to be read and discussed by a wide audience. The letter concludes with a request for the editor to accept the work for publication.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6411

CERTIFICATE OF DEATH

06421

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U. S. General Hospit</u>				d. STREET ADDRESS <u>14 Acton Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Sara</u> Middle <u>Sutherland</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>6-</u> Day <u>13-</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1886</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Dr David Cameron Sutherland</u>				14. MOTHER'S MAIDEN NAME <u>Kate Scott Armicost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Miss India SUTHERLAND #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Necrotizing pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/17</u> , 19 <u>58</u> , to <u>6/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/12</u> , 19 <u>58</u> , and that death occurred on <u>6/13</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard K. Peeler</u> M.D.				ADDRESS (Street, city or town, state) <u>230 P. CATHEDRAL ST -</u> DATE SIGNED <u>6/14/58</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD K. PEELER</u>				ANNAPOILIS, MD-			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Anne's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sins</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>JUN 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Green</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>10/15/1918</i>	
PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
COUNTY <i>Harford</i>		STATE <i>Md.</i>	
AGE <i>45</i>		SEX <i>Male</i>	
OCCUPATION <i>Farmer</i>		EDUCATION <i>High School</i>	
MARRIED <input checked="" type="checkbox"/> YES SINGLE <input type="checkbox"/> NO		RELIGION <i>Methodist</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF BURIAL <i>10/17/1918</i>		PLACE OF BURIAL <i>Greenwood Cemetery</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESSES <i>John Smith, Mary Jones</i>	
DATE OF SIGNATURE <i>10/15/1918</i>		PLACE OF SIGNATURE <i>Home</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESSES <i>John Smith, Mary Jones</i>	
DATE OF SIGNATURE <i>10/15/1918</i>		PLACE OF SIGNATURE <i>Home</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESSES <i>John Smith, Mary Jones</i>	
DATE OF SIGNATURE <i>10/15/1918</i>		PLACE OF SIGNATURE <i>Home</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

6441

CERTIFICATE OF DEATH

Reg. Dist. No. 06422

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crofton Burnie</i>	c. LENGTH OF STAY IN 1b <i>6/13/58</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto.</i> <i>3401-4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mazen Manor Nursing Home</i>		d. STREET ADDRESS <i>2724 E. Chase St.</i>	
3. NAME OF DECEASED (Type or print) <i>Nancy</i> First <i>—</i> Middle <i>—</i> Last <i>Hallette</i>		4. DATE OF DEATH Month <i>6</i> Day <i>20</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1893</i> 9. AGE (In years last birthday) <i>64</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Cape Charles Va.</i>
13. FATHER'S NAME <i>George Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Belle Robinson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Tamer Cheek</i> Address <i>2724 E. Chase St.</i>		12. CITIZEN OF WHAT COUNTRY?	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage.</i> <i>443x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio Vascular Disease</i> (c) <i>Arteriosclerotic Cardio Vascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Right Hemiplegia</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-13</i> , 19 <i>58</i> , to <i>6-20</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6-13</i> , 19 <i>58</i> , and that death occurred at <i>8:30 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Felous Greenberg</i> M.D.		ADDRESS (Street, city or town, state) <i>10 Jeff St Odenton Md.</i> DATE SIGNED <i>6/20/58</i>	
PHYSICIAN'S NAME (Type) <i>Felous Greenberg</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>6/24/1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cape Charles Va.</i>	22d. LOCATION (City, town or county) (State) <i>Cape Charles Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs Kate R. Williams</i> ADDRESS <i>322 N. Schroeder St.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 23 '58</i>	24b. REGISTRAR'S SIGNATURE <i>—</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AnneArundel Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15X-2</u> d. STREET ADDRESS <u>6113 Willmott</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Chesler</u> First <u>A.</u> Middle <u>Hammett</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Ridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Spencer Hammett</u>				14. MOTHER'S MAIDEN NAME <u>Kate Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-07-1518</u>		17. INFORMANT <u>J. William Hammett-Same Item #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Autopsy</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Howard</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6/20/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/20/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>7557 Wis. Ave. Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the cause thereof in the "Remarks" section. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
6442
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6442
CERTIFICATE OF DEATH

06424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 12y 4m 27d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Vernon d. STREET ADDRESS 19x-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Last Harris		4. DATE OF DEATH Month 6 Day 23 Year 1958	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1881	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Jones (Deceased)		14. MOTHER'S MAIDEN NAME Jane Shield (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Hospital Records		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 DUE TO Ventricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACVD DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from January 6, 1955, to June 23, 1958 , that I last saw the deceased alive on June 23, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Heard Reissmann		DATE SIGNED 6/24/58	
PHYSICIAN'S NAME (Type) Hildegard Reissmann, M. D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 6-25-58		22b. DATE THEREOF 6-25-58	
22c. NAME OF CEMETERY OR CREMATORY Balto. Md.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JUL 1 1958	
24b. REGISTRAR'S SIGNATURE W. Reese			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6443

Item 11-File # 231 - 7/16/58-mb
 Item 2-File # 231 - 7-17-58-ec

CERTIFICATE OF DEATH

Reg. Dist. No.

06425

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>--</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Geo G Meade Md</u>				c. LENGTH OF STAY IN 1b <u>Just arriving</u> PCS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U S Army Hospital</u>				d. STREET ADDRESS <u>Avondale Estates</u> Not given			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W</u> Last <u>Harrison</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 March 1908</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>--</u> Days <u>--</u> Hours <u>--</u> Min. <u>--</u>	IF UNDER 24 HRS. Months <u>--</u> Days <u>--</u> Hours <u>--</u> Min. <u>--</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Army</u>		11. BIRTHPLACE (State or foreign country) <u>AVONDALE ESTATES, GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>deceased</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy A Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>259-07-7687</u>		17. INFORMANT Address <u>Sgt Withey, Post Personnel Rcds, Ft Meade, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction, acute</u> <u>420.1</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>--</u> DUE TO <u>--</u> (c) <u>--</u> DUE TO <u>--</u>						INTERVAL BETWEEN ONSET AND DEATH <u>--</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>--</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>--</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>--</u> a. m. <u>19</u> p. m. <u>--</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u>	
20f. (City or town) <u>--</u>				20g. (County) <u>--</u>		20h. (State) <u>--</u>	
21. I certify that I attended the deceased from <u>22 June</u> , 19 <u>58</u> , to <u>22 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>22 June</u> , 19 <u>58</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George B. Hagan, Capt, MC</u>				ADDRESS (Street, city or town, state) <u>Ft Meade, Md.</u>			
DATE SIGNED <u>22 June 58</u>							
PHYSICIAN'S NAME (Type) <u>GEORGE B HAGAN Capt MC</u>							
22a. DATE OF CREMATION, REMOVAL (Specify) <u>6/25/58</u>		22b. DATE THEREOF <u>6/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>A. S. Turner Morticians</u>		22d. LOCATION (City, town, or county) (State) <u>Decatur, Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Woberton</u>				ADDRESS <u>Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. R. Smith</u>	

6306 - Belair Rd - Baltimore 6, Md

I, the undersigned, received the body of SFC John W Harrison, RA 34 4/1 476 from the U S Army Hospital, Fort George G Meade, Md at 2030 hours, 24 June 1958 in good condition.

Earl B Wolverton Funeral Home Inc.,
6306 Belair Rd., Baltimore, Md

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 20 Film 230 6-18-58 am					Item 6 Film G230 6-11-58 et						
6413					Reg. Dist. No. 06426						
1. PLACE OF DEATH a. COUNTY <i>A.A.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN lb					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A.A. General Hospital</i>					d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>T.</i> Last <i>Hart</i>					4. DATE OF DEATH Month <i>6</i> Day <i>1</i> Year <i>1958</i>						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug-18-1928</i>		9. AGE (In years last birthday) <i>29</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meat Cutter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Meat Cutter</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Thomas Hart</i>					14. MOTHER'S MAIDEN NAME <i>Grace F. Nicholson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>WW II</i>					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Rose Marie Hart</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing injury to chest</i> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Sudden</i> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car ran off road down bank</i>						
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>02</i> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Route 178</i>		20f. (City or town) <i>Iglehart</i> (County) <i>AA</i> (State) <i>Md.</i>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John Hart</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <i>E. L. in h. m. d. t.</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					22b. DATE THEREOF <i>6-4-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Washington National</i>		22d. LOCATION (City, town, or county) (State) <i>Washington Va</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>					ADDRESS <i>Annapolis</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Ch. Deauch</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED: <u>WALLY AND STAYE</u></p>		<p>DATE OF DEATH: <u>10/10/10</u></p>	
<p>RESIDENCE: <u>10 HEATH BASTORE</u></p>		<p>AGE: <u>10</u></p>	
<p>SEX: <u>MALE</u></p>		<p>CAUSE OF DEATH: <u>HEART DISEASE</u></p>	
<p>DATE OF EXAMINATION: <u>10/10/10</u></p>		<p>PLACE OF EXAMINATION: <u>HOME</u></p>	
<p>NAME OF EXAMINER: <u>DR. J. H. BASTORE</u></p>		<p>ADDRESS OF EXAMINER: <u>10 HEATH BASTORE</u></p>	
<p>SIGNATURE OF EXAMINER: <u>[Signature]</u></p>		<p>DATE OF SIGNATURE: <u>10/10/10</u></p>	
<p>NAME OF WITNESS: <u>DR. J. H. BASTORE</u></p>		<p>ADDRESS OF WITNESS: <u>10 HEATH BASTORE</u></p>	
<p>SIGNATURE OF WITNESS: <u>[Signature]</u></p>		<p>DATE OF SIGNATURE: <u>10/10/10</u></p>	
<p>NAME OF DECEASED: <u>WALLY AND STAYE</u></p>		<p>DATE OF DEATH: <u>10/10/10</u></p>	
<p>RESIDENCE: <u>10 HEATH BASTORE</u></p>		<p>AGE: <u>10</u></p>	
<p>SEX: <u>MALE</u></p>		<p>CAUSE OF DEATH: <u>HEART DISEASE</u></p>	
<p>DATE OF EXAMINATION: <u>10/10/10</u></p>		<p>PLACE OF EXAMINATION: <u>HOME</u></p>	
<p>NAME OF EXAMINER: <u>DR. J. H. BASTORE</u></p>		<p>ADDRESS OF EXAMINER: <u>10 HEATH BASTORE</u></p>	
<p>SIGNATURE OF EXAMINER: <u>[Signature]</u></p>		<p>DATE OF SIGNATURE: <u>10/10/10</u></p>	
<p>NAME OF WITNESS: <u>DR. J. H. BASTORE</u></p>		<p>ADDRESS OF WITNESS: <u>10 HEATH BASTORE</u></p>	
<p>SIGNATURE OF WITNESS: <u>[Signature]</u></p>		<p>DATE OF SIGNATURE: <u>10/10/10</u></p>	

6414

CERTIFICATE OF DEATH

06427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Mulberry Hill</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Johnson</u>				4. DATE OF DEATH Month Day Year <u>June 11 19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1958</u>	
				9. AGE (In years last birthday) yrs. <u>11</u>		10. UNDER 1 YEAR Months Days Hours Min <u>11 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>James Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Rt. 3, Box 371, Mulberry Hill, Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>under development</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-10-58</u> , 19 <u>58</u> , to <u>6-11-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-11-58</u> , 19 <u>58</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>AT Allen</u> M.D. <u>CL Caldwell</u> ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>6-14-58</u>							
PHYSICIAN'S NAME (Type) <u>AT ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pineview Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Jones</u>				ADDRESS <u>1100 N. Annapolis Rd.</u>		24a. REC'D BY REGISTRAR <u>JUN 18 '58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Jones</u>			

2063336XVO

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

6415

CERTIFICATE OF DEATH

06429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELLA</u> First <u>ISABEL</u> Middle <u>Langley</u> Last		4. DATE OF DEATH <u>June</u> Month <u>7</u> Day <u>1958</u> Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 25, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. county</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Henry Lester</u>		14. MOTHER'S MAIDEN NAME <u>Emma Walters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son, Robert R. Langley</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Carcinomatosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>6-7-58</u> , to <u>6-7-58</u> , 19 <u>6-7-58</u> , that I last saw the deceased alive on <u>6-7-58</u> , 19 <u>6-7-58</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. HAHN</u>		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>6-7-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		<u>Severna Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Langley</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>MIN 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert R. HAHN</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EX-100/100 EX-100/100

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU ONE 15

CERTIFICATE OF DEATH

Page 1 of 1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1930-01-15		Baltimore, Maryland	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Physician's Signature		Physician's Title		Physician's Address	
1975-03-10		10:00 AM		[Signature]		MD		123 Main St, Baltimore, MD	
Burial or Disposition		Burial		Cremation		Other		Place of Burial	
Buried		Cremated		Other		Other		Catholic Cemetery	
Date of Burial		Time of Burial		Burial Place		Burial Place		Burial Place	
1975-03-15		10:00 AM		Catholic Cemetery		Catholic Cemetery		Catholic Cemetery	

CERTIFICATE OF DEATH

06430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lamar Nursing Home</u>				d. STREET ADDRESS <u>604 Newfield Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Battie</u> Middle <u>Rebecca</u> Last <u>Langsville</u>				e. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/19/1884</u>	
9. AGE (In years last birthday) <u>73 1/4</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>James Borgan</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Faulkner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Carcinomatosis.</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Uterus with</u> DUE TO (c) <u>metastasis.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardio Vascular Disease - Left Hemiplegia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/12</u> , 19 <u>58</u> to <u>6/11</u> , 19 <u>58</u> that I last saw the deceased alive on <u>6/19/58</u> , 19 <u>58</u> , and that death occurred at <u>3:30 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Febus Graunberg</u> M.D.				ADDRESS (Street, city or town, state) <u>10 Gill St. Odenton Md</u>			
PHYSICIAN'S NAME (Type) <u>Febus Graunberg</u>				DATE SIGNED <u>6/14/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Hirtle</u> ADDRESS <u>Glen Burnie</u>				24a. REC'D BY REGISTRAR <u>JUN 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

CERTIFICATE OF DEATH

General Communication -
Communications of various with
institutions -

Hypertensive (acute) disease - not hypertensive

Feb 28 1954
John F. ...
10 Mill St. ...
Feb 28 1954

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6416

Item 7 Film G231 7-7-58 et

Reg. Dist. No.

06431

1. PLACE OF DEATH a. COUNTY <u>ANNE.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis General Hosp.</u>				d. STREET ADDRESS <u>309 Haskell Plr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>A</u> Middle <u>H</u> Last <u>Lettau</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1958</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>27</u> Hours <u>0</u> Min. <u>0</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Art Glazier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Bellaire, Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ernest D. Lettau</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Mangold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Ernest G. Lettau, Arnold, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> <u>Caduce</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause last. DUE TO (c) <u>Interval between onset and death</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>00</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6x8 7-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Deane</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6445

CERTIFICATE OF DEATH

06432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie 5mth</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3401-4 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manor Nursing Home</i>			d. STREET ADDRESS <i>27 N. Carey St.</i>		
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>Johnson</i> Last <i>Lewis</i>			4. DATE OF DEATH Month <i>6</i> Day <i>28</i> Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Co.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-27-1875</i>	9. AGE (In years last birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lab. Dir.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Maryland</i>	
13. FATHER'S NAME <i>John Lewis</i>			14. MOTHER'S MAIDEN NAME <i>Mary Snowden</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Harris Chambers - 2142 Aiken Street</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Carcinomatosis</i> <i>181.0</i> DUE TO <i>Carcinoma of Bladder</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>-</i> DUE TO <i>-</i> (c) <i>-</i>					INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Cardiovascular Disease</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>-</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>	20f. (City or town) <i>-</i>	(County) <i>-</i> (State) <i>-</i>
21. I certify that I attended the deceased from <i>4-2-1958</i> to <i>6-28-1958</i> , that I last saw the deceased alive on <i>6-21-1958</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Febus Graunberg</i>			ADDRESS (Street, city or town, state) <i>10 Guil St Odenton Md.</i>		
PHYSICIAN'S NAME (Type) <i>Febus Graunberg</i>			DATE SIGNED <i>6-28-1958</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-3-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>			ADDRESS <i>802 Madison Avenue</i>		
24a. REC'D BY REGISTRAR <i>DUL 1 '58</i>			24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>		

MEDICAL CERTIFICATION

No. _____ Harris Chambers - 2142 Aiken Street Calvert Co., Maryland		No. _____ Harris Chambers - 2142 Aiken Street Calvert Co., Maryland	
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6446

CERTIFICATE OF DEATH

Reg. Dist. No. 06433

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) ANNAPOLIS			
c. LENGTH OF STAY IN 1b 5 years				d. STREET ADDRESS CAPE ST. CLAIRE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAPE ST. CLAIRE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GRETCHEN MASER LUSBY				4. DATE OF DEATH JUNE 24 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (Pharmacist)		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) NEBRASKA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME P. MASER				14. MOTHER'S MAIDEN NAME WEPPNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT MRS. ROSALIND BETTS				Address Rt. 2, Box 99, Stafford, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of sigmoid colon DUE TO (c) with extensive metastases						INTERVAL BETWEEN ONSET AND DEATH 4 hours 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1957 , to May 1958 , that I last saw the deceased alive on May 1958 , and that death occurred at 7:22 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 Cathedral St. Annapolis, Md. DATE SIGNED June 24, 1958							
ACTUAL SIGNATURE Jesse L. Wilkins M.D.							
PHYSICIAN'S NAME (Type) JESSE L. WILKINS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF June 28, 1958		22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE JUN 26 58		W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6447
CERTIFICATE OF DEATH

06434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1516 Argyle Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard		4. DATE OF DEATH Month 6 Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilitic and Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/28 , 19 58 , to 6/4 , 19 58 , that I last saw the deceased alive on 6/4 , 19 58 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md.			
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville State Hospital, Md.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58	
22c. NAME OF CEMETERY OR CREMATORY Balto Nat'l Cem.		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Carlington J. Phillips		ADDRESS 1808-10 N. Home Memorial St	
24a. REC'D BY REGISTRAR Jun 10 '58		24b. REGISTRAR'S SIGNATURE W. J. ...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6448

CERTIFICATE OF DEATH

Reg. Dist. No. 06435

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>				d. STREET ADDRESS <u>Furnace Branche Lee Road</u>			
3. NAME OF DECEASED (Type or print) <u>Edward Middleton</u>				4. DATE OF DEATH <u>6-7-1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-1887</u>	
9. AGE (In years last birth day) <u>70</u> yrs.		IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.		IF UNDER 24 HRS. <u>—</u> Days <u>—</u> Hours <u>—</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Balt Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Middleton</u>				14. MOTHER'S MAIDEN NAME <u>Anne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Cousin</u> Address <u>1204 Myrtle Ave Balt.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-5-1958</u> , to <u>6-7-1958</u> , that I last saw the deceased alive on <u>6-5-1958</u> , and that death occurred at <u>3:40</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Felix Grunberg</u> M.D.				ADDRESS (Street, city or town, state) <u>10 Gill St Odenton</u> DATE SIGNED <u>6-7-58</u>			
PHYSICIAN'S NAME (Type) <u>Felix Grunberg</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Catharine Cem. Balt.</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Kate R. Williams</u> ADDRESS <u>Schroeder St.</u>				24a. REC'D BY REGISTRAR <u>JUN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Date of Birth		Date of Death		Place of Birth		Place of Death	
1900-01-01		1900-01-01		Baltimore, Md.		Baltimore, Md.	
Age		Sex		Race		Religion	
10		Male		White		Roman Catholic	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death	
Heart Failure		Heart Failure		Heart Failure		Natural	
Disease		Symptoms		Examination		Disposition	
Coronary Artery Disease		Chest Pain		Autopsy		Buried	
Date of Burial		Date of Interment		Place of Interment		Name of Interment	
1900-01-01		1900-01-01		St. Mary's Cemetery		St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]	

MARYLAND, STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
6449 CERTIFICATE OF DEATH									
Reg. Dist. No. 06436									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 47X3				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel					c. LENGTH OF STAY IN 1b 4 months				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School					d. STREET ADDRESS 5100 - 2nd Street N.W.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Hunter Middle Jay Last Mills			4. DATE OF DEATH		Month June Day 26 Year 1958	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1955		9. AGE (In years lost birthday) 3 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Grady Mills					14. MOTHER'S MAIDEN NAME Peggy Ann England				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --			16. SOCIAL SECURITY NO. --		17. District Training School Address Children's Center			Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-vascular collapse secondary to 299X DUE TO aspiration Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Post erythroblastosis DUE TO (c) Post erythroblastosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral palsy with severe mental retardation									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from February 14, 1958 to June 26, 1958 , that I last saw the deceased alive on June 26, 1958 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.					ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED				
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF June 27, 1958		22c. NAME OF CEMETERY OR CREMATORY District Training School			22d. LOCATION (City, town, or county) (State) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Nooney Jr. ADDRESS					24a. REC'D BY REGISTRAR JUL 2 '58		24b. REGISTRAR'S SIGNATURE W. H. Seach		

• 2 •

3112 y/b+2d sm2/11w

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6417

CERTIFICATE OF DEATH

Reg. Dist. No.

06437

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Matthew (n) MOORE Jr.</u>				4. DATE OF DEATH Month Day Year <u>June 18 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18, 1958</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Matthew MOORE</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Virginia HICKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Erythroblastosis fetalis</u> <u>770.5</u> DUE TO <u>ABO incompatibility ???</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrops fetalis - prematurity</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 18</u> , 19 <u>58</u> , to <u>June 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>58</u> , and that death occurred at <u>7:05</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>110 Clay St., Annapolis, Maryland</u> DATE SIGNED <u>June 19, 1958</u>							
ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D.				PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u>				ADDRESS <u>108 Wash St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beesett</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1880		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE AVE.		CLOCK REPAIRER		HEART DISEASE		NATURAL		HOME	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 20 1925		10:30 AM		10		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1925		JAN 20 1925		JAN 20 1925		JAN 20 1925		JAN 20 1925	

6418

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>aa</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater R. 7 D. #3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A. General Hospt.</u>		d. STREET ADDRESS <u>Annapolis</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James William Moulden</u>		4. DATE OF DEATH Month <u>6</u> - Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-5-1908</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u> Hours <u>49</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator Construction</u>		12. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Frederick W. Moulden</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-8634</u>	
17. INFORMANT <u>Eva Kathryn Moulden</u>		18. ADDRESS <u>(2)</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>9-5-</u> 19 <u>58</u> , to <u>6-22-58</u> , that I last saw the deceased alive on <u>6-6-58</u> , and that death occurred at <u>230 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		DATE SIGNED <u>6-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral St Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '58</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6450 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06439

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Unknown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Country Club Estate, Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On West Side of Cedar Avenue</u>				d. STREET ADDRESS <u>25 Howard Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Willis Munch</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21st.</u> Year <u>1958</u> 19			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/2/04</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bridge Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ridgeland, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>W.A. Munch</u>				14. MOTHER'S MAIDEN NAME <u>Emily B. Janette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-09-7909</u>		17. INFORMANT <u>James W. Munch Jr. (son), same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self Inflamed wound to the brain with a</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>22 caliber rifle.</u> (c) <u> </u> DUE TO (a), stating the underlying cause lost. <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>See # 18</u>					
20c. TIME OF INJURY Month, Day, Year <u>6/21/58</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cedar Avenue</u>		20f. (City or town) <u>Glen Burnie, Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>June 22 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematorium</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF MICHIGAN
DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH: 1900-09-09

DEATH OF: [Name]

PLACE OF DEATH: [Location]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6451

CERTIFICATE OF DEATH

06440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. STREET ADDRESS 1801 Madison Avenue			
3. NAME OF DECEASED (Type or print) First Florence Middle Burket Last Nichols				4. DATE OF DEATH Month 6 Day 27 Year 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 11, 1913	
9. AGE (In years lost birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rice Burket				14. MOTHER'S MAIDEN NAME Margaret			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Generalized Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 6/9 , 19 58 , to 6/27 , 19 58 , that I last saw the deceased alive on 6/27 , 19 58 , and that death occurred at 10:00 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED _____ ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville State Hospital, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R Law				24a. REC'D BY REGISTRAR JUL 1 '58		24b. REGISTRAR'S SIGNATURE Al. Beach	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Illegible]</p>		<p>AGE [Illegible]</p>	
<p>SEX [Illegible]</p>		<p>RACE [Illegible]</p>	
<p>DATE OF BIRTH [Illegible]</p>		<p>DATE OF DEATH [Illegible]</p>	
<p>PLACE OF BIRTH [Illegible]</p>		<p>PLACE OF DEATH [Illegible]</p>	
<p>RESIDENCE [Illegible]</p>		<p>CAUSE OF DEATH [Illegible]</p>	
<p>DIAGNOSIS [Illegible]</p>		<p>IMMEDIATE CAUSE OF DEATH [Illegible]</p>	
<p>INTERVIEWED BY [Illegible]</p>		<p>DATE OF INTERVIEW [Illegible]</p>	
<p>SIGNATURE OF DECEASED [Illegible]</p>		<p>SIGNATURE OF WITNESS [Illegible]</p>	
<p>DATE OF SIGNATURE [Illegible]</p>		<p>DATE OF SIGNATURE [Illegible]</p>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6452

CERTIFICATE OF DEATH

Reg. Dist. No.

06441

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN TB <i>85 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>		3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>—</i> Last <i>Parks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manor Nursing Home</i>		d. STREET ADDRESS <i>939 W. Fayette</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <i>June</i> Day <i>26</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-1-1884</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	IF UNDER 24 HRS. Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shop factory worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Lincoln Co., Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jessy Parks</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-05-3257</i>	
17. INFORMANT Address <i>Ernest Hawkins 939 W. Fayette Street</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) <i>Generalized Arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Left Hemiplegia Post. Cerebral Vascular</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> p. m. <i>—</i> 19 <i>58</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-1</i> , 19 <i>58</i> , to <i>6-25</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6-25</i> , 19 <i>58</i> , and that death occurred at <i>12:00 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Febus Gaunberg</i> M.D.		ADDRESS (Street, city or town, state) <i>10 Gill St. Odenton Md</i>	
PHYSICIAN'S NAME (Type) <i>Febus Gaunberg</i>		DATE SIGNED <i>June 26-1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-28-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i> ADDRESS <i>802 Madison Avenue</i>		24a. REC'D BY REGISTRAR <i>JUN 30 58</i> 24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6419

CERTIFICATE OF DEATH

Reg. Dist. No.

06442

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General Hspt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>E</u> Middle <u>POOLE</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB - 6 - 1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EVEREST H. POOLE</u>		14. MOTHER'S M maiden NAME <u>VIOLET S. THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Richard Poole Edgewater Md Co. 442</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>June 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>58</u> , and that death occurred at <u>6:15</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6/29/58</u>			
ACTUAL SIGNATURE <u>John C. Hedeman</u> M.D.			
PHYSICIAN'S NAME (Type) <u>John C. Hedeman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-30-58</u>		22b. DATE THEREOF <u>6-30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Son Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>			

1

6453 Item 2 Film G230 6-19-58 et

06443

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Beth.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 11m 21d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2045 N. East Street			
3. NAME OF DECEASED (Type or print) First George Middle Edgar Last Queen				4. DATE OF DEATH Month 6 Day 9 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Accident DUE TO (c) Carcinoma of the Prostate with Metastases							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Decompensation with Pulmonary Edema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 6/18 , 19 57 , to 6/9 , 19 58 , that I last saw the deceased alive on 6/9/58 , and that death occurred at 7:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 6/10/58			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				Crownsville State Hospital, Md. 6/10/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORY U. of Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Geese, Jr. - Ann. Md.				24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE W. Geese	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and signature. The form is mostly blank with some faint markings.

1925

1925 p 15 22-11-28
1925 p 15 22-11-28

6454

CERTIFICATE OF DEATH

06444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>1950</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>116 Wooddale Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Antoinette</u> Last <u>Rand.</u>		4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 21, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Guidoeph Hausck</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2205</u>	
17. INFORMANT <u>Daughter</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>6-11-58</u> , 19____, that I last saw the deceased alive on <u>6-11-58</u> , 19____, and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u> M.D.		DATE SIGNED <u>6-11-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 29</u>	
24a. REC'D BY REGISTRAR <u>JUN 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert R. Hahn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The form is oriented horizontally but the text is mirrored.

JAMES BOND

IN FULL

6-14-55
London Park Cem.
Belle, Me.
2107 Wilkins Ave. 22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6420

CERTIFICATE OF DEATH

Reg. Dist. No.

06445

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SHERWOOD FOREST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>G</u> Last <u>RASIN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 5th 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>BLANCHARD EMDRY</u>		14. MOTHER'S MAIDEN NAME <u>MARY BOURKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>W# DAVIDSON</u>	
17. INFORMANT <u>St. MARGARETS, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis, generalized</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-3-</u> , 19 <u>56</u> to <u>6-23-</u> , 19 <u>58</u> that I last saw the deceased alive on <u>6-28-58</u> , 19 <u>58</u> , and that death occurred at <u>12-USA</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D. <u>121 Cathedral St</u> <u>6-25-58</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u> <u>annapolis Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Mo.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Poff + Sons</u> <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alb. Smith</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6455

CERTIFICATE OF DEATH

06446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Linthicum</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#406 Oakgrove Road</u>				d. STREET ADDRESS <u>#406 Oakgrove Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>PHEBE</u> Middle <u>A.</u> Last <u>REWIG</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 22/79</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Truscott</u>				14. MOTHER'S MAIDEN NAME <u>Maria Lotterrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>none</u>		17. INFORMANT <u>Mrs. Carolyn Goetz</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Cardio-Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____ DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u> </u> , to <u>June 22/ 19 58</u> , that I last saw the deceased alive on <u>June 14/ 19 58</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>6/23/58</u>			
PHYSICIAN'S NAME (Type) <u>Charles L. Ball, M.D.</u>				<u>Linthicum Heights, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Patterson, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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DEATH

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6456

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6457

CERTIFICATE OF DEATH

06448

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oklahoma b. COUNTY Comanche	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		d. STREET ADDRESS 1212 Carroll Drive	
3. NAME OF DECEASED (Type or print) First Carolyn Middle Schneider Last Schneider		4. DATE OF DEATH Month June Day 20 Year 19 58	
5. SEX Female	6. COLOR OR RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 September 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR: Months 7 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Peusch		14. MOTHER'S MAIDEN NAME Lenora Grimm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Melva E. Viskocil (daughter)		223 Ferndale Rd., Glen Burnie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that deceased was hospitalized from 27 May 58 to 20 June 58 that I last saw the deceased alive on 20 June 19 58 , and that death occurred at 2300 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Raymond J. Gould		M.D. U. S. ARMY HOSPITAL, FT. MEADE, MD. 20 Jun 58	
PHYSICIAN'S NAME (Type) RAYMOND J. GOULD, CAPT., MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Brackley Rd. 146	
23. FUNERAL DIRECTOR'S SIGNATURE H. V. Singleton ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 '58	
		24b. REGISTRAR'S SIGNATURE W. J. Seach	

6458

CERTIFICATE OF DEATH

Reg. Dist. No. **06449**

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>St. Louis</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Louis MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burgess</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. Louis Hosp</u>				e. STREET ADDRESS <u>Cumpley MD.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM C</u> First <u>Schultz</u> Last				4. DATE OF DEATH <u>June 5</u> - <u>1958</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25-1904</u> <u>54</u> yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Road</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry F. Schultz</u>				14. MOTHER'S MAIDEN NAME <u>Ida E. Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-34-0515</u>		17. INFORMANT <u>Ruby F. Schultz</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pneumonia</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6/14</u> , 19 <u>58</u> , to <u>6/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/15</u> , 19 <u>58</u> , and that death occurred at <u>10:20</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Borosnick</u> M.D.				ADDRESS (Street, city or town, state) <u>Burgess MD</u> DATE SIGNED <u>6/15/58</u>			
PHYSICIAN'S NAME (Type) <u>S. Borosnick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>St. Louis MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blond G. Fink</u> ADDRESS <u>Blond G. Fink MD</u>				24a. REC'D BY REGISTRAR DATE <u>9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6459

CERTIFICATE OF DEATH

06450

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Round Bay, C.C. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Servane Rd</u> <u>Rural</u>				c. LENGTH OF STAY IN 1b <u>20 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>L.</u> Last <u>Sege</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 25, 1901</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Model</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Modesty clerk</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Eustace A. Schoening</u>				14. MOTHER'S MARRIED NAME <u>Welchman?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>111-111-1111</u>		17. INFORMANT <u>Wm. Sege</u>		Address <u>Servane Rd C.C. Co Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung & Lung</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the Intestine</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19 <u>56</u> , to <u>June 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>58</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>James S. Billingsley</u> M.D. <u>108 Cedar St</u> <u>Edin Barnes Md June 17, 1958</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Annas</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

CERTIFICATE OF DEATH

1923

NAME OF DECEASED [Handwritten Name]		SEX [Handwritten Sex]		AGE [Handwritten Age]	
DATE OF DEATH [Handwritten Date]		PLACE OF DEATH [Handwritten Place]		TIME OF DEATH [Handwritten Time]	
CAUSE OF DEATH [Handwritten Cause]		MANNER OF DEATH [Handwritten Manner]		PLACE OF BURIAL [Handwritten Place]	
NAME OF PHYSICIAN [Handwritten Name]		NAME OF CLERGYMAN [Handwritten Name]		NAME OF FUNERAL HOME [Handwritten Name]	
NAME OF NEXT OF KIN [Handwritten Name]		NAME OF SURVIVOR [Handwritten Name]		NAME OF WITNESS [Handwritten Name]	
NAME OF DECEASED'S MOTHER [Handwritten Name]		NAME OF DECEASED'S FATHER [Handwritten Name]		NAME OF DECEASED'S SPOUSE [Handwritten Name]	
NAME OF DECEASED'S BROTHER [Handwritten Name]		NAME OF DECEASED'S SISTER [Handwritten Name]		NAME OF DECEASED'S CHILD [Handwritten Name]	
NAME OF DECEASED'S GRANDFATHER [Handwritten Name]		NAME OF DECEASED'S GRANDMOTHER [Handwritten Name]		NAME OF DECEASED'S UNCLE [Handwritten Name]	
NAME OF DECEASED'S AUNT [Handwritten Name]		NAME OF DECEASED'S NEPHEW [Handwritten Name]		NAME OF DECEASED'S NIECE [Handwritten Name]	
NAME OF DECEASED'S COUSIN [Handwritten Name]		NAME OF DECEASED'S FIRST COUNSELOR [Handwritten Name]		NAME OF DECEASED'S SECOND COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S THIRD COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FOURTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FIFTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S SIXTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S SEVENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S EIGHTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S NINTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S TENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S ELEVENTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S TWELFTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S THIRTEENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FOURTEENTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S FIFTEENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S SIXTEENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S SEVENTEENTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S EIGHTEENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S NINETEENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S TWENTIETH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S TWENTY-FIRST COUNSELOR [Handwritten Name]		NAME OF DECEASED'S TWENTY-SECOND COUNSELOR [Handwritten Name]		NAME OF DECEASED'S TWENTY-THIRD COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S TWENTY-FOURTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S TWENTY-FIFTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S TWENTY-SIXTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S TWENTY-SEVENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S TWENTY-EIGHTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S TWENTY-NINTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S THIRTIETH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S THIRTY-FIRST COUNSELOR [Handwritten Name]		NAME OF DECEASED'S THIRTY-SECOND COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S THIRTY-THIRD COUNSELOR [Handwritten Name]		NAME OF DECEASED'S THIRTY-FOURTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S THIRTY-FIFTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S THIRTY-SIXTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S THIRTY-SEVENTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S THIRTY-EIGHTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S THIRTY-NINTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FORTY COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FORTY-FIRST COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S FORTY-SECOND COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FORTY-THIRD COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FORTY-FOURTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S FORTY-FIFTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FORTY-SIXTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FORTY-SEVENTH COUNSELOR [Handwritten Name]	
NAME OF DECEASED'S FORTY-EIGHTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FORTY-NINTH COUNSELOR [Handwritten Name]		NAME OF DECEASED'S FIFTY COUNSELOR [Handwritten Name]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06451

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

6460

Item 18 Film 232 7-31-58

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo Md		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT SELLMAN		4. DATE OF DEATH Month June Day 22 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-1926 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry Sellman		14. MOTHER'S MAIDEN NAME Margaret Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 213-22-0002	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X DUE TO Bronchial Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-27-58	
22c. NAME OF CEMETERY OR CREMATORY Adams Chapel Bayand Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108 Wash. St. Annapolis		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
24b. REGISTRAR'S SIGNATURE Alber...		DATE SIGNED 6/23/58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6461

CERTIFICATE OF DEATH

06452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>212 ARUNDEL ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY MARIE BARBARA Spiegel</u>				4. DATE OF DEATH <u>June 23 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1906</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>FRANCIS X. Schmitt</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANNA FRANZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>August J. Spiegel, 212 Arundel Rd Aa</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subacute bacterial endocarditis</u> <u>414X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/15</u> , 19 <u>57</u> , to <u>6/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/23</u> , 19 <u>58</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morton M. Krieger</u> M.D.				ADDRESS (Street, city or town, state) <u>5010A Ritchie Highway -25-</u>			
PHYSICIAN'S NAME (Type) <u>MORTON M. KRIEGER MD.</u>				DATE SIGNED <u>5010A RITCHIE HIGHWAY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 26</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Bence</u> ADDRESS <u>4001 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR <u>W. H. 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. 30 '58</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6421

CERTIFICATE OF DEATH

Reg. Dist. No.

06453

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U. A. General Hospt</u>		d. STREET ADDRESS <u>117 Academy St</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>D.</u> Last <u>Stanley</u>		4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales. for Cola Bottling Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>7a</u>	9. AGE (In years last birthday) <u>57</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John C. Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2ena D. Stanley</u>	
17. INFORMANT <u>2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>John</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1, 1956</u> , to <u>June 12, 1958</u> , that I last saw the deceased alive on <u>6-12-1958</u> , and that death occurred at <u>10:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Smith</u> M.D.		DATE SIGNED <u>6/13/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sins</u>		24a. REC'D BY REGISTRAR <u>June 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION	
John Doe		45		Male		White		Married		Teacher	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
Jan 15, 1921		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		PREVIOUS ILLNESS		HISTORY	
Jan 1, 1876		Maryland		High School		Roman Catholic		None		None	
DATE OF INTERMENT		PLACE OF INTERMENT		CEREMONY		BURIAL		CREMATION		OTHER	
Jan 18, 1921		St. Mary's Church		Catholic		Buried		None		None	
DATE OF REPORT		PLACE OF REPORT		REPORTER		SIGNATURE		TITLE		ADDRESS	
Jan 16, 1921		Home		John Doe		John Doe		Teacher		123 Main St.	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6422

CERTIFICATE OF DEATH

Reg. Dist. No.

06454

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>527 Second St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Myrtle Ann Stephen</i>		4. DATE OF DEATH <i>6-11-1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-7-1890</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas Kelley</i>	
14. MOTHER'S MAIDEN NAME <i>Mary E. Wiggins</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>1</i>		17. INFORMANT <i>Carl F. Stephen #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>606x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic pyelitis</i> DUE TO (c) <i>Neurogenic bladder</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>3 yrs</i> <i>5 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I, <i>John C. Hedeman</i> , certify that I attended the deceased from <i>June 10</i> , 19 <i>58</i> , to <i>June 11</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>June 10</i> , 19 <i>58</i> , and that death occurred at <i>10:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C. Hedeman</i>		ADDRESS (Street, city or town, state) <i>121 Cathedral St. Annapolis, Md.</i>	
DATE SIGNED <i>6/13/58</i>		PHYSICIAN'S NAME (Type) <i>Annapolis, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-14-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hellerest</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>June 15 '58</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur Smith</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6462

CERTIFICATE OF DEATH

06455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 21y 5m 26d		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace 1224.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nelson		4. DATE OF DEATH Month 6 Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1870
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months 6 Days 24	11. IF UNDER 24 HRS. Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Taylor		14. MOTHER'S MAIDEN NAME Eliza Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic hypertensive cardiovascular disease DUE TO (c) 20yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senile degeneration INTERVAL BETWEEN ONSET AND DEATH 8yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from January 6, 1955 to June 24, 1958 , that I last saw the deceased alive on June 24, 1958 , and that death occurred at 1:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Reissmann		M.D. Crownsville State Hospital, Md. 6/24/58	
PHYSICIAN'S NAME (Type) Hildegard Reissmann, M. D.		Crownsville State Hospital, Md. 6/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) General		22b. DATE THEREOF 6-25-58	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Md.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 1 '58	
24b. REGISTRAR'S SIGNATURE W. Reese			

CERTIFICATE OF DEATH

FILE NO.

DATE

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF BIRTH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF PREVIOUS DEATH

CAUSE OF PREVIOUS DEATH

DATE OF PREVIOUS DEATH

CAUSE OF PREVIOUS DEATH

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6463

CERTIFICATE OF DEATH

06458

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Essex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN 1b 11 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. ARMY HOSPITAL				d. STREET ADDRESS Caret 83x-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First RYLAND Middle EUGENE Last TAYLOR				4. DATE OF DEATH Month June Day 25 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 June 1911		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Taylor				14. MOTHER'S MAIDEN NAME Ida Collier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 223-26-7972		17. INFORMANT Mrs Audrey P Dillard		Address Caret, Virginia (Sister)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO - VASCULAR ACCIDENT 331X DUE TO CEREBRO-VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 10 HOURS 10 Hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I have signed the deceased's name, _____, 19____, that I last saw the deceased alive on 25 June 19 58 , and that death occurred at 2333 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Samuel D. Gaby M.D. U.S. ARMY HOSP, FT MEADE, MD 25 Jun 58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) SAMUEL D. GABY, MD, US. ARMY HOSP, FT GEO G MEADE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		June 25-58		Upper Essex-Baptist Caret		Va.	
23. FUNERAL DIRECTOR'S SIGNATURE D. V. Singleton				24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Deedman	

06457

6423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>98 Shipwright</i>		e. STREET ADDRESS <i>198 Shipwright St.</i>	
3. NAME OF DECEASED (Type or print) First <i>ROGER</i> Middle <i>THOMAS</i> Last <i>THOMAS</i>		4. DATE OF DEATH Month <i>6-</i> Day <i>16</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-6-1896</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Archivist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W. Hall & Records</i>	
11. BIRTHPLACE (State or foreign country) <i>Cleveland Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Sebastian Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Mary Catherine Huntsberger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Elizabeth M. Thomas (2)</i>	
17. INFORMANT <i>Elizabeth M. Thomas</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Coronary Artery Disease</i> DUE TO (c) <i>3 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-4-</i> <i>1957</i> , to <i>6-16-</i> <i>1958</i> , that I last saw the deceased alive on <i>5-23-</i> <i>1958</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M Shipley</i>		DATE SIGNED <i>6-19-58</i>	
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>		ADDRESS (Street, city or town, state) <i>121 Cathedral St - Annapolis, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>6-20-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>In Co. Co Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Scyclus</i>		24a. REC'D BY REGISTRAR <i>JUN 23 '58</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6424

CERTIFICATE OF DEATH

Reg. Dist. No. 06458

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Anna Arundel General Hospital</u>		d. STREET ADDRESS <u>3031 Sedgwick St. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>J. Frederick Wenchel</u>		4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/74</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>George Wenchel</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Gradwohl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Adam G. Wenchel</u>		Address <u>3803 Blackthorn St. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>6-21</u> , 19 <u>58</u> , to <u>6-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>58</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u>	
DATE SIGNED <u>6-22-58</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>JUN 24 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REG. DIV. 12

1. NAME OF DECEASED JOHN J. HANCOCK		2. SEX MALE	
3. AGE 62		4. DATE OF BIRTH 1881	
5. PLACE OF BIRTH NEW YORK		6. OCCUPATION RETIRED	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1915	
9. PLACE OF DEATH HOME		10. CAUSE OF DEATH HEART DISEASE	
11. DATE OF DEATH 1943		12. TIME OF DEATH 10:00 AM	
13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF REGISTRAR [Signature]	
15. PLACE OF INTERMENT GREENWICH CEMETERY		16. NAME OF CEMETERY GREENWICH CEMETERY	
17. NAME OF FUNERAL HOME JOHN J. HANCOCK		18. ADDRESS OF FUNERAL HOME 1234 MAIN ST.	
19. NAME OF NEXT OF KIN MRS. J. J. HANCOCK		20. ADDRESS OF NEXT OF KIN 1234 MAIN ST.	
21. NAME OF FUNERAL HOME JOHN J. HANCOCK		22. ADDRESS OF FUNERAL HOME 1234 MAIN ST.	
23. NAME OF FUNERAL HOME JOHN J. HANCOCK		24. ADDRESS OF FUNERAL HOME 1234 MAIN ST.	
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97. NAME OF FUNERAL HOME JOHN J. HANCOCK		98. ADDRESS OF FUNERAL HOME 1234 MAIN ST.	
99. NAME OF FUNERAL HOME JOHN J. HANCOCK		100. ADDRESS OF FUNERAL HOME 1234 MAIN ST.	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. DATE OF MARRIAGE
9. PLACE OF DEATH
10. CAUSE OF DEATH
11. DATE OF DEATH
12. TIME OF DEATH
13. SIGNATURE OF PHYSICIAN
14. SIGNATURE OF REGISTRAR
15. PLACE OF INTERMENT
16. NAME OF CEMETERY
17. NAME OF FUNERAL HOME
18. ADDRESS OF FUNERAL HOME
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100. ADDRESS OF FUNERAL HOME

6464

CERTIFICATE OF DEATH

06459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47x-3</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Children's Center</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Jerome Young</u>				4. DATE OF DEATH Month Day Year <u>June 11 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/48</u>	9. AGE (In years last birthday) <u>9</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nipthurnell Young</u>				14. MOTHER'S MAIDEN NAME <u>Garonia Pitts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>2</u>		17. INFORMANT <u>Nipthurnell Young</u> 1302 St. N.E., Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>infectious diarrhea</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral birth injury with mental retardation</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>5/16</u> , 19 <u>58</u> to <u>6/11/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>58</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.		ADDRESS (Street, city or town, state) <u>Children's Center</u>		DATE SIGNED <u>6/13/58</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>		Laurel, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>D.T.S. cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md. Anne Arundel</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Young Jr.</u>				ADDRESS <u>Supt. D.T.S. Laurel, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
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88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
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97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
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